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On

Medicare Savings Plans and Low Income Subsidy: Keeping Medicare's Promise or Seniors and People with Disabilities

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Chairman Pallone and members of the Committee, thank you for giving me the opportunity to talk to you today about the Medicare Savings Programs (also known as “QMB”, “SLMB” and “QI-1”), Medicare Part D Low-Income Subsidy Program (hereinafter “Low-Income Subsidy Program”) and their impact on people with disabilities. My name is John Coburn and I am a Senior Policy Attorney for Health & Disability Advocates and the Director of the Illinois-based Make Medicare Work Coalition. Health & Disability Advocates (HDA) is a national policy and advocacy group that works to promote policies and programs that ensure the economic security and comprehensive health coverage for children and adults with disabilities and older adults, particularly those with limited incomes. A major part of our work is assisting individuals, community-based service providers, and advocates in understanding and navigating the complicated state and federal benefits systems, identifying barriers to accessing those systems, developing policies and solutions that will eliminate those barriers, and assuring that polices promote rather than hinder an individual’s efforts to gain or maintain employment.

We are also one of the founding groups, along with AgeOptions and Progress Center for Independent Living, of the Make Medicare Work Coalition. The Make Medicare Work Coalition is a unique collaboration of community-based service providers who are doing the

day-to-day education and outreach around Medicare Part D. My organization, HDA, provides technical assistance, training and policy support to this Coalition. We have worked in more than ten other states on issues ranging from auto enrollment, patient assistance programs and impact of Part D on the AIDS Drugs Assistance Programs. We have also worked with more than 30 states who have been working to build Medicaid Buy-In programs and Medicaid-funded employment supports for adults with disabilities – the majority of which are Medicare beneficiaries.

While our Coalition assists all Medicare beneficiaries, I want to focus my testimony on Medicare beneficiaries with disabilities under the age of 65. There are approximately 7 million younger individuals with disabilities enrolled in Medicare, representing approximately 16% of the Medicare population.[1] Most of these individuals qualify for Medicare because of current or former eligibility for Social Security Disability Insurance (hereinafter "SSDI") and completion of the required 24 month waiting period.

For these younger Medicare beneficiaries with disabilities, the Medicare Savings Programs and the Low-Income Subsidy Program are extremely important. The average SSDI check in 2007 is only

[1] http://www.kff.org/medicare/upload/7615.pdf at page 4.

$950.[2] If the average SSDI beneficiary were forced to pay Part B and Part D costs, Medicare would be unaffordable. With the assistance of the Medicare Savings Programs and Low-Income Subsidy Program, many individuals are able to access proper and necessary medical care under Medicare Part B and Medicare Part D.

For Medicare beneficiaries with disabilities, the issues and concerns with Medicare Savings Programs and the Low-Income Subsidy Program are many and varied. However, these issues are often overshadowed by those of the aging community. In my limited time before you, I will focus on two particular issues that are very important to Medicare beneficiaries with disabilities: the impact of employment income and returning to work on continued eligibility for these programs; and some proposed steps we recommend to improve the auto-enrollment of Medicare beneficiaries into the Low-Income Subsidy Program to ensure that they are enrolled in a Prescription Drug Plan that best meets their needs.

The Impact of Employment Income on Continued Eligibility for Medicare Savings Program and the Low-Income Subsidy Program

Individuals with disabilities want to live securely and safely in their communities. Employment within the community is a key component of any strategy to better integrate individuals with

[2] www.healthlaw.org/library.cfm?fa=download&resourceID=95155&print at page 1.

disabilities into the daily life of their communities. A 2004 National Organization on Disability/Harris Survey, only 35 percent of people with disabilities reported being employed full or part time, compared to 78% of those who do not have disabilities.[3] However, 72% of the individuals with disabilities surveyed want to work.[4] Over the years, Congress, the Social Security Administration and the Centers for Medicare and Medicaid Services have worked to create and implement programs and policies that remove the barriers to employment of working age Medicare beneficiaries, including the fear of loss of affordable health care. The hallmark legislation behind this effort has been the Ticket to Work and Work Incentives Improvement Act of 1999, which included provisions that extended Medicare eligibility for Medicare beneficiaries that return to work.

I. Eligibility requirements for Medicare Savings Programs and the Low-Income Subsidy Program should encourage, not punish, those individuals who choose to become employed.

The impact of earnings on eligibility for the Medicare Savings Programs and Low-Income Subsidy Program is now a significant consideration for any Medicare beneficiary's decision to return to work. Unfortunately, the Medicare Modernization Act of 2003 (hereinafter "MMA") and its implementing regulations did not adequately address

[3] http://www.at508.com/040624_national_press_club.cfm.
[4] http://www.whitehouse.gov/news/freedominitiative/freedominitiative.html.

how the Low-Income Subsidy Program would integrate within the existing framework of SSDI programs that promote work – known as work incentives programs. An additional complication is that the Medicare Savings Programs have never been required to create eligibility standards that encourage employment of working-age beneficiaries. These mis-steps have resulted in the derailment of years of policy development work that Congress, the Social Security Administration and the Centers for Medicare and Medicaid have done to assure that SSDI beneficiaries are encouraged to seek employment and a higher level of self-sufficiency.

SSDI beneficiaries do not receive their Medicare benefits in a vacuum. Rather, a negative impact on eligibility for the Medicare Savings Programs and Medicare Low-Income Subsidy Program will continue to serve as disincentives to working despite the presence of the SSDI work incentives. The Medicare Savings Programs and Low-Income Subsidy Program must work in concert with the SSDI work incentives, the Medicaid Buy-In Programs, and the myriad of other state and federal programs that promote work and greater self-sufficiency for individuals with disabilities. By not doing so, we are left with a system that works at cross purposes: what the SSDI work incentives and other employment-related support programs give with

one hand, the Medicare Savings Program and Low-Income Subsidy Program takes away with the other.

Eligibility for Medicare Savings Programs and the Low-Income Subsidy Program is determined by level of income and assets. How income is counted for Medicare Savings Programs varies from state to state but most, if not all, programs do count some level of earned income. As required under the MMA, the income calculation for the Low-Income Subsidy Program follows the Supplemental Security Income methodology. Under both programs, increasing earned income puts continuing eligibility in jeopardy.

Given a choice between continued eligibility for Medicare Savings Programs and the Low-Income Subsidy Program, securing employment and working more hours, many individuals will choose to remain in the Programs. Unfortunately, in many typical cases, this makes the most financial sense. The earnings from the new job or an increase in income cannot possibly make up for the loss in benefits that accrue from enrollment in the Medicare Savings Programs and the Medicare Part D Low- Income Subsidy. Instead, individuals are forced to turn down job opportunities, work fewer hours, or not accept raises.

II. Medicaid Buy-In Programs provide a partial safety net from loss of eligibility for the Medicare Part D Low-Income Subsidy eligibility. However, Medicaid Buy-In Programs alone are not enough.

Under Section 4733 of the Balanced Budget Act of 1997 or the Ticket to Work and Work Incentives Improvement Act of 1999, 32 states have implemented Medicaid Buy-In Programs for individuals with disabilities.[5] Recognizing the importance of comprehensive health care benefits to individuals with disabilities, these two Acts provided states with the flexibility to create programs that allow individuals to gain employment and "buy-in" or pay a premium to keep or obtain Medicaid coverage. There are approximately 80,000 people participating in this program.[6]

The vast majority (76%) of Medicaid Buy-In participants are Medicare beneficiaries.[7] In our work with the states and these programs, we find that states who track disability-type report a significant number of their Medicaid Buy-In participants are living with a mental illness. And, states have reported that pharmaceutical expenses are the primary driver of expenditures in their programs. From this, we can deduce with some certainty that individuals worked and joined Medicaid Buy-In Programs prior to Medicare Part D because of the drug coverage that allowed them to work successfully. Now,

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[5] http://www.cms.hhs.gov/TWWIA/07_BuyIn.asp#TopOfPage
[6] Id.
[7] Mathematica Policy Research, Inc., Understanding Enrollment Trends and Participant Characteristics of the Medicaid Buy-In Program, 2003-2004. Final Report, January 2006. Page xv.

because Buy-In participants are considered dual eligibles under the Low-Income Subsidy Program, participants will continue enrollment to maintain that dual eligible status.

The Medicaid Buy-In Programs do give many individuals the flexibility to work and maintain their Medicare Part D Low-Income Subsidy Program eligibility. However, the income and eligibility criteria vary from state to state and will not cover all individuals interested in working who need to maintain Low-Income Subsidy eligibility. For example, states such as Maine, Michigan and West Virginia have stricter unearned income guidelines than the Low-Income Subsidy Program. South Carolina requires a higher level of earned income than other states to get into the state's Medicaid buy-in program. Alaska and South Carolina limit an individual's assets to levels lower than that of the Medicare Savings Program and the Low-Income Subsidy Program. Most importantly, individuals living in the 18 states without Buy-In Programs, including large states like Ohio, North Carolina, Georgia and Florida, cannot rely on these Buy-In programs period.

The patchwork of Medicaid Buy-In Programs cannot remove the work disincentive inherent in the Medicare Savings Programs and the Low-Income Subsidy Program. Rather, only a change at the federal

level can assure that any SSDI beneficiary is not forced to choose between affordable health care and a job.

III. The Medicare Savings Programs and the Low-Income Subsidy Eligibility Requirements Continue to Prevent Individuals from Working and/or Being More Self-Sufficient.

The examples that follow will give you an idea of the unenviable choices some Medicare beneficiaries have to make when thinking about employment. These examples represent the experiences of many Medicare beneficiaries we and our fellow advocates have assisted in making an informed choice about returning to work.

> *Ms. B lives in Ohio, where no Medicaid Buy-In Program currently exists. Ms. B currently receives $850 in SSDI, QMB assistance, and the Low-Income Subsidy. She is living with a mental illness. It was a huge step for her to decide to return to work, but she made the decision to do it. She secured an offer for a full-time job. When she found out that she would lose her QMB assistance and eligibility for the Low-Income Subsidy, she had to turn the job down. It would be impossible for her to afford her co-pays for her doctor's visits and medications. .*
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> *Ms. J is a single female in her thirties living in Illinois. She currently receives $646 in SSDI, Medicare, QMB assistance with Medicare expenses, Medicaid and the full low-income subsidy. Ms. J really wants to work and was applying for part-time jobs in her community that paid approximately $600 per month. Since she lives in such a rural area, she would need a car. She found a friend who was willing to drive her to work for a while until she is able to save enough from her paycheck to buy a used car. If Ms. J were to take this job, eligibility for these various programs would change dramatically. With an extra $600 in gross income, she will lose eligibility for QMB assistance and will begin to pay the $93.50 premium for Medicare Part B. She could either continue regular Medicaid eligibility with a significant monthly spenddown/share of cost, or join Illinois Health Benefits for*

Workers with Disabilities, the state's Medicaid Buy-In Program. That program would cost her another $50 in a monthly premium. After taxes and these additional premiums of $143.50, working at this level is never going to allow her to save money to get the car she needs. By working any more than this, she would lose her eligibility for the Health Benefits for Workers with Disabilities Program and her eligibility for the Part D Low-Income Subsidy. Therefore, Ms. J has decided not to work.

Ms. S has a dual diagnosis of mental illness and a visual impairment. She is in her late 50's, is married, and lives in Illinois. Her husband is disabled and retired. Both receive Social Security, Medicare and QMB assistance. Shirley is a part-time student and she works part-time as a local mental health center. Because of her earnings, both she and her husband lost their QMB eligibility. Having to suddenly pick up the cost of two premiums of $93.50 and the 20% cost share of Medicare Part B was unaffordable. Almost all of her earned income was going to pay these expenses. So, Ms. S reduced her work hours in order to re-qualify for the QMB Medicare Savings Program.

IV. 1619(A) and (B) of the Social Security Act[8] Provide an Excellent Example of How to Assure That the Inability to Keep Affordable Medical Coverage Is Not a Barrier to Employment.

In contrast to the experience of the SSDI beneficiaries receiving Medicare, Supplemental Security Income ("SSI") beneficiaries who receive Medicaid are given wide latitude to work and maintain their affordable health care. They are able to do this through provisions of the Social Security Act commonly known as "1619 Medicaid." Under these provisions, an individual who receives SSI and Medicaid and still needs Medicaid to work can continue to receive Medicaid at no cost up to certain income limits. These income limits are based on each

[8] 42 USC § 426(b); POMS HI 00820.025.

state's average Medicaid expenditures but can be increased in individual cases. For example, in Illinois, an individual receiving SSI benefits and Medicaid can earn up to $31,011 per year without losing Medicaid coverage.[9]

Creating a similar rule in the Medicare Savings Programs and the Low-Income Subsidy Program would eliminate the work disincentive in those Programs. When conducting re-determinations, work income could be disregarded up to the state's 1619(b) threshold just as it is for SSI beneficiaries. This would allow individuals such as Ms. B, Ms. J and Ms. S to work and maintain affordable health insurance. The cost of such an expansion would be minimal as it would not necessarily add new people to these two Programs. Rather, it would allow current enrollees to gain employment that they would not otherwise accept because of loss of eligibility for the Programs.

Improvements to the Formulary Requirements of Precription Drug Plans to Which Individuals are Automatically Assigned

For those automatically enrolled into the Low-Income Subsidy Program and a Prescription Drug Plan, more can be done to assure that the assignment is appropriate and will meet the person's needs.

> *Mr. G is an SSDI beneficiary with both Medicare and Medicaid. Living with a mental illness, he was prescribed a specific anti-psychotic drug that has worked well for several years. He was auto-enrolled into a Prescription Drug Plan in October of 2006.*

[9] http://www.ssa.gov/redbook/2007rbnews.htm

That plan would not allow him access to this anti-psychotic without trying a preferred drug first even though that violated CMS policy guidance. The exception was denied, so he began taking the preferred drug. He had to be hospitalized and his health has deteriorated significantly.

Individuals automatically enrolled into Prescription Drug Plans continue to face serious problems in accessing their needed medications. While others will talk more about these issues, I want to briefly identify and discuss one key issue. Many individuals with disabilities find that even after being properly assigned to a PDP that identifies the proper cost sharing, a process that takes entirely too long for some, they still cannot get the medication that they need because of formulary restrictions. Since individuals with disabilities represent over 1/3 of dual eligibles and dual eligibles are auto-enrolled into plans, this is a serious issue for the disability community.[10]

Under the MMA Act, Prescription Drug Plans must carry two drugs in each therapeutic category.[11] Under sub-regulatory guidance to the Prescription Drug Plans, CMS has directed the Prescription Drug Plans to carry "*all or substantially all*" of the drugs in six drug categories: Anti-convulsants, Anti-retrovirals, Immuno-suppressants, Anti-depressants, Anti-psychotics and Anti-neoplastics.[12] These drugs

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[10] http://www.cms.hhs.gov/MCBS/Downloads/CNP_2003_dhsec8.pdf at page 37.
[11] http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FormularyGuidance.pdf at page 7.
[12] Centers for Medicare and Medicaid Services. Medicare Prescription Drug Benefit Manual. Chapter 6 at 30.2.5.

also have enhanced protections from benefits management tools.[13] Because this second requirement is only sub-regulatory guidance, it could be removed in future years by CMS.

These requirements alone are important but inadequate to assure that those who are automatically enrolled into Prescription Drug Plans will have access to the medications they need. In particular, the enhanced protection for the 6 classes is crucial in assuring better access to life-saving medications. We believe that if this requirement was not instituted in the guidance, many more beneficiaries would have suffered serious health consequences. This guidance prevented what would have been an unmitigated, widespread public health crisis into "merely" a serious problem for a substantial number of people.

Two recent studies, dealing with individuals who take at least some drugs within the enhanced protected categories, are evidence of the serious and continuing access problem. The first study was conducted by the HIV Medicine Association and the American Academy of HIV Medicine. Of 452 HIV medical providers surveyed, it found that 76% reported having patient(s) living with HIV who could not access a medication due to formulary restrictions.[14] The second study was published in the American Journal of Psychiatry. Surveying 1183

[13] Id.

[14] American Academy of HIV Medicine and the HIV Medicine Association, "HIV Medical Provider Medicare Part D Survey." April 2, 2007.

psychiatrists, it found that 30.6% of them reported having dual-eligible patients who were not able to access medications because the Part D plans did not cover or approve the prescription.[15]

Continued access to medications and no breaks in coverage are absolutely necessary to managing serious conditions such as HIV and mental illness. Every attempt must be made to assure access to necessary medications for these and other serious conditions experienced by Medicare beneficiaries with disabilities. If not, these vulnerable Medicare beneficiaries face grave health consequences. Even with the protection for the 6 classes, the medications needs of a significant portion of these Medicare populations are not being met.

More must be done to assure that individuals are assigned to Prescription Drug Plans that meet their needs. Congress should codify into law the important protections for the 6 classes of drugs currently covered by sub-regulator guidance. These protections are absolutely necessary to assure Part D is adequate to meet the needs of the populations taking these medications. The disability community needs more assurance than just sub-regulatory guidance that must be renewed from year to year that these requirements will continue. In addition, CMS should have more authority and be provided more resources to enforce the compliance by Prescription Drug Plans on

[15] Joyce C. West, Ph.D. et. al. "Medication Access and Continuity: The Experiences of Dual-Eligible Psychiatric Patients during the First 4 Months of Medicare Prescription Drug Benefit." American Journal of Psychiatry, May 2007, page 789.

these and all other requirements. Given the experience of both the HIV and mental health community, it is clear that not enough has been done. While CMS is very responsive when specific examples are brought to its attention, it would be much more efficient and effective if such measures were taken up-front without constant prompting from the advocacy community when gaps and issues are discovered.

The Prescription Drug Plans to which individuals are automatically assigned receive these enrollees with no "acquisition costs." No money must be spent on marketing to encourage them to join the plan and no staff time must be spent enrolling them into the plan. In return for this, it would not be unreasonable to place further requirements on these plans to assure that these individuals have easier access to the medications prescribed to them. Those requirements could include enhanced protection beyond the current 6 categories to include more of the common medications prescribed to the Low-Income Subsidy population.

Conclusion

The Medicare Savings Programs and the Low-Income Subsidy Program are extremely important to Medicare beneficiaries with disabilities. Without them, Medicare would be unaffordable for many. Given the importance of these Programs, it is troubling that current law and policy would force individuals with disabilities to choose

between eligibility for these Programs and employment. Expansion of these programs to allow individuals to work and become more self-sufficient within their communities as well as stronger assurances that Medicare Part D covers necessary drugs would go far in improving these Programs for people with disabilities.

Thank you.